We believe this conference has changed the culture of our program by normalizing attention to cognitive errors, integrating bias discussions into clinical rounds, and emphasizing metacognitive strategies in the face of uncertainty. We have observed that trainees embrace curricula that prepare them to tackle cognitive errors. Utilizing the cognitive autopsy in a safe, collaborative conference setting has proved to be an effective approach to deliver this curriculum. By providing a safe space to discuss cognitive errors, we are creating clinicians who are better equipped to tackle diagnostic uncertainty and ultimately provide safer care to patients.

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NEW IDEAS

A Culture of Safety From Day 1: An Institutional Patient Safety Initiative to Support Incoming Interns

Setting and Problem

To maximize the quality of care and protect patients, on the first day of residency incoming interns must understand the specific ways their new institution creates a culture of safety. To support transitioning trainees and cultivate our medical center's culture of safety, we developed an authentic, large-scale immersive patient safety simulation called First Night-onCall (FNOC).

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Intervention

Before participating in FNOC, incoming interns completed 5 WISE-onCall online educational modules geared toward providing incoming interns with a just-in-time framework to approach acute inpatient complaints such as chest pain or hypotension. The FNOC orientation event is a 4-hour immersive simulation (FIGURE) during which new interns, in groups, were challenged to conduct an ethical informed consent, evaluate a decompensating hypotensive patient and activate a rapid response team (escalation), document a clinical encounter, recognize a mislabeled blood culture bottle, conduct an effective patient handoff, recognize common patient safety hazards in a simulated patient room, and participate in patient safety rounds. During the simulation, learners interacted with standardized patients and nurses who assessed the learners using behaviorally anchored checklists. Faculty interacted with the learners and debriefed all activities. All learners completed a preprogram assessment, a retrospective pre-post assessment of their own perspectives, attitudes, and skills, and a program evaluation.

Outcomes to Date

A total of 145 incoming interns from 56 medical schools, entering training in 7 departments (internal medicine, surgery, neurological surgery, neurology, emergency medicine, obstetrics and gynecology, and orthopedic surgery) completed FNOC. Despite 61% (n = 133) reporting to have witnessed a medical error during medical school, only 35% of interns reported any formal training in patient safety. Prior to FNOC, relatively few interns reported being comfortable speaking to a supervisor (56%), escalating a situation (38%), or reporting a medical error (27%).

Outcomes from the simulation demonstrated that entering interns were not yet consistently able to recognize and demonstrate common safety practices. Learners were only able to, on average, recognize 35% of the common environmental patient safety hazards. In the group assessments, 63% of the groups (n = 46) called a rapid response team for the decompensating patient, while only 22% contacted the senior resident; 70% of groups (n = 44) recognized a blood culture bottle that was mislabeled, while only 33% alerted the nurse assisting in the blood draw; and 67% of the groups (n = 46) inquired

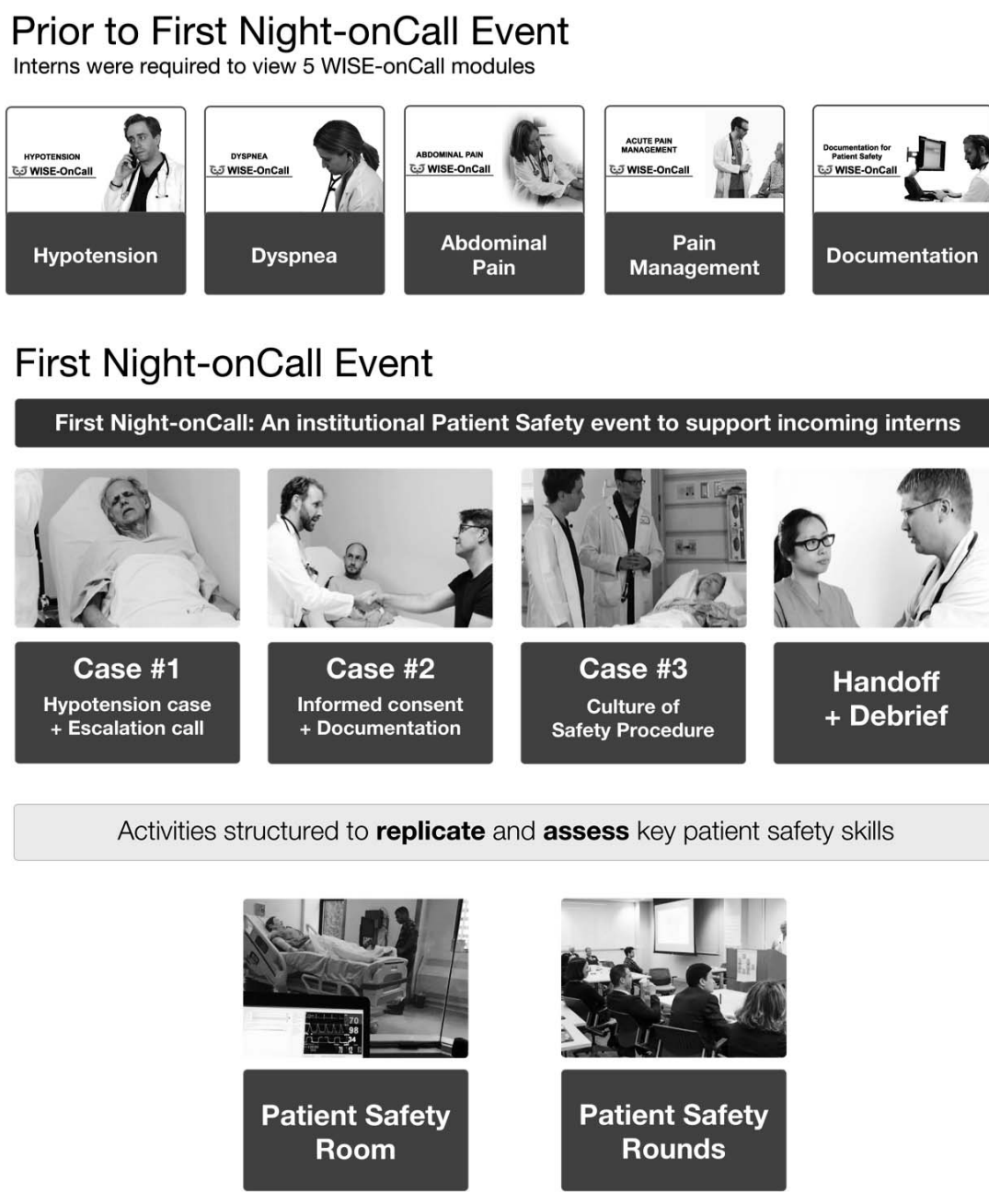

FIGURE
Methodological Design for First Night-onCall Experience

whether consent could be discussed in the presence of another adult at the bedside.

After FNOC, interns were asked to write commitments to what they would do in the future to participate in a culture of safety. The most common responses included checking identification/labels (90%), asking for help/escalating (83%), and communicating effectively (65%). Post-FNOC, more than 94% of interns reported increased comfort in speaking to a supervisor, escalating a situation, and reporting a medical error. Of the 86% of learners who completed all 5 online modules, more than 90% agreed that the modules increased readiness-for-internship. Our large-scale experiential patient safety simulation was both feasible and acceptable. Timing of the educational event was important for priming learning and serving as an introduction to the community and institutional expectations. Interns (n = 133) agreed that the FNOC experience was an effective way to learn patient safety (99%), a good approach to improve readiness (96%), fun (93%), and engaging (100%). Lasting impact will be

evaluated by follow-up assessments, including rates of rapid response team activation and patient safety incident reporting across our clinical enterprise.

Engaging, immersive, innovative, simulation-based group experiences like FNOC may reduce the variability seen in incoming interns and instill aspirational institutional norms—generating a culture of safety and providing a framework for effective on-boarding strategies for novice health care providers.

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NEW IDEAS

How to Make It Real: Disparities of Care Experiential Learning Workshop

Setting and Problem

According to the Clinical Learning Environment Review (CLER) National Report of Findings, disparities of care is an area in need of more development. Only 30% of clinical learning environments had some type of training in cultural competency that was tailored to the population being served. Across most clinical learning environments, education in the areas of health care disparities and cultural competency was largely generic, often did not address the specific populations served by the institution, and occurred in an ad hoc manner. In our 2016 CLER site visit report, the site reviewer commented, "The [organization] does not appear to have a systematic approach to identifying variability in the care provided to or the clinical outcomes of their known vulnerable patient populations." To address this gap in training, our graduate medical education office intervened with the Disparities of Care Experiential Workshop. Every resident from our organization's training programs (emergency medicine, family medicine, internal medicine, obstetrics and gynecology, podiatric medicine and surgery, and psychiatry) attended the workshop.

Intervention

The workshop objectives were to identify disparities of care (eg, health insurance, transportation, health literacy, care transitions) specific to our population. Prior to the workshop, a work group investigated and identified the region's health care disparities, and the organizations that could act as a bridge to address that disparity. Collaboration was initiated with the local Women, Infants, and Children offices, the Federally Qualified Health Center clinic, durable medical equipment store, compounding pharmacy, Commission on Aging, and the local bus system. The residents electronically signed up to evenly distribute themselves among the locations. On the day of the workshop, the CLER Pathways and report were

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